

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16170

FILED MAY 14 1953

State File No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4096

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (If this place) 4 days		c. CITY OR TOWN St. Louis 2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				e. STREET ADDRESS (If rural, give location) 3636 French Avenue			
3. NAME OF DECEASED (Type or Print) ELIZABETH				a. (First) b. (Middle) c. (Last) SCHAEFER		4. DATE OF DEATH (Month) (Day) (Year) April 19, 1953	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Married		8. DATE OF BIRTH Jan. 21, 1888	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At home		9. AGE (In years last birthday) 65		11. BIRTHPLACE (City and State or Foreign Country) Hungary	
13a. FATHER'S NAME Konrad Schadel				13b. MOTHER'S MAIDEN NAME Anna Kramer		14. NAME OF HUSBAND OR WIFE Henry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry Schaefer 3636 French Ave. St. Louis	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cellulitis of Prof. wall (b) Diabetes Mellitus (c) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Ch. Stomach Dis. & Intest.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 260X			
22. I hereby certify that I attended the deceased from 6-30-1920, to 4-19-1953, that I last saw the deceased alive on 4-18-1953, and that death occurred at 1:30 A.M., from the causes and on the date stated above.							
23a. SIGNATURE W. Enders M.D.				23b. ADDRESS 1602 S. Rudy		23c. DATE SIGNED 4-20-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Apr. 22, 1953		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum		24d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Road	
DATE REC'D BY LOCAL REG. APR 20 1953		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 781 1/2 So. Broadway St. Louis 11 Mo.			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.